Filing at a Glance

Company:	Ameritas Life Insurance Corp.
Product Name:	4504LS - Disability Income Product
State:	Arkansas
TOI:	H11I Individual Health - Disability Income
Sub-TOI:	H11I.004 Other
Filing Type:	Form/Rate
Date Submitted:	08/02/2012
SERFF Tr Num:	AMFA-128526847
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	4504LS ET AL.
Implementation Date Requested:	On Approval
Author(s):	Cindy Meyer, Joanne Friend, Bobbie Cramer
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	08/03/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Ameritas Life Insurance Corp.*
TOI/Sub-TOI: *H11I Individual Health - Disability Income/H11I.004 Other*
Product Name: *4504LS - Disability Income Product*
Project Name/Number: *4504LS - Disability Income Product/4504LS et al.*

General Information

Project Name: 4504LS - Disability Income Product
Project Number: 4504LS et al.
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Bobbie Cramer

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/03/2012
State Status Changed: 08/03/2012
Created By: Bobbie Cramer
Corresponding Filing Tracking Number:

Filing Description:

Re: Ameritas Life Insurance Corp.
NAIC No. 0943-61301
FEIN No. 47-0098400

Submission Form Identification: 4504LS, et al – Individual Disability Income Policy, Endorsement and Applications
Designation of Form as Individual or Group Market: Individual
General Description of Submission: Individual Disability Income policy, endorsement and applications as shown on attached Exhibit A.

Enclosed for your review and approval is a new Disability Income policy, applicable rates, and other forms shown in Exhibit A for use with Ameritas Life Insurance Corp. All of these forms are new and will be used for future sales only. They will have no effect on in force policies. Exhibit A includes the flesch score information for each form being submitted. A brief description of the above referenced forms is included (see Exhibit B) along with the Actuarial Memorandum.

No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. Since our printers use various fonts and layouts, we reserve the right to format the pages to conform to the printer's requirements. No change in language will occur, only a possible page break, or renumbering of a page.

The enclosed forms were submitted concurrently to our domiciliary state of Nebraska. If you have any questions or comments regarding this filing, please refer them to me at 1-800-825-1551, extension 52329 or via email at: bcramer@ameritas.com. Thank you for your consideration of this submission. Be assured it is appreciated.

Sincerely,

Bobbie Cramer
Senior Contract Analyst

Company and Contact

Filing Contact Information

Bobbie Cramer, Senior Contract Analyst
1876 Waycross Road
P O Box 40888
Cincinnati, OH 45240

bcramer@ameritas.com
800-825-1551 [Phone] 52329 [Ext]
513-595-2918 [FAX]

State: *Arkansas* ***Filing Company:*** *Ameritas Life Insurance Corp.*
TOI/Sub-TOI: *H11I Individual Health - Disability Income/H11I.004 Other*
Product Name: *4504LS - Disability Income Product*
Project Name/Number: *4504LS - Disability Income Product/4504LS et al.*

Filing Company Information

Ameritas Life Insurance Corp.
5900 O Street
P O Box 81889
Lincoln, NE 68501-1889
(800) 756-1112 ext. [Phone]

CoCode: 61301
Group Code: 943
Group Name:
FEIN Number: 47-0098400

State of Domicile: Nebraska
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $500.00
Retaliatory? No
Fee Explanation: $50 x 9 forms = $450.00
$50 x 1 rate = $50.00

Total = $500.00
Per Company: No

Company	Amount	Date Processed	Transaction #
Ameritas Life Insurance Corp.	$500.00	08/02/2012	61392619

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***		***Company Tracking #:***	*4504LS ET AL.*

State:	*Arkansas*	***Filing Company:***	*Ameritas Life Insurance Corp.*
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Product Name:	*4504LS - Disability Income Product*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/03/2012	08/03/2012

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***		***Company Tracking #:***	*4504LS ET AL.*

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Disposition

Disposition Date: 08/03/2012
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Ameritas Life Insurance Corp.	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***		***Company Tracking #:***	*4504LS ET AL.*

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Product Name:	*4504LS - Disability Income Product*		
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statements of Variability	Approved-Closed	Yes
Supporting Document	Exhibits A and B	Approved-Closed	Yes
Form	Disability Income Policy	Approved-Closed	Yes
Form	Disability Income Outline of Coverage	Approved-Closed	Yes
Form	Exclusions/Limitations Endorsement	Approved-Closed	Yes
Form	Application for Disability Income Insurance - Personal Information	Approved-Closed	Yes
Form	Application for Disability Income Insurance - Policy Details	Approved-Closed	Yes
Form	Application for Disability Income Insurance - Policy & Financial Information	Approved-Closed	Yes
Form	Application for Disability Income Insurance - Lifestyle & Health Questionnaire	Approved-Closed	Yes
Form	Application for Disability Income Insurance - Agreement	Approved-Closed	Yes
Form	Application for Reinstatement/Policy Change - Disability Income Insurance	Approved-Closed	Yes
Rate	Annual Rates per $1,000	Approved-Closed	Yes

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***		***Company Tracking #:***	*4504LS ET AL.*

State:	*Arkansas*	***Filing Company:***	*Ameritas Life Insurance Corp.*
TOI/Sub-TOI:	*H11I Individual Health - Disability Income/H11I.004 Other*		
Product Name:	*4504LS - Disability Income Product*		
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Form Schedule

Lead Form Number: 4504LS AR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/03/2012	4504LS AR	POL	Disability Income Policy	Initial:	55.000	4504LS AR.pdf
2	Approved-Closed 08/03/2012	4504LS OC	OUT	Disability Income Outline of Coverage	Initial:	52.000	4504LS OC std.pdf
3	Approved-Closed 08/03/2012	AEXENM	POLA	Exclusions/Limitations Endorsement	Initial:	62.000	AEXENM.pdf
4	Approved-Closed 08/03/2012	UN 2555 PI 6-12	AEF	Application for Disability Income Insurance - Personal Information	Initial:	60.000	UN 2555 PI 6-12.pdf
5	Approved-Closed 08/03/2012	UN 2555 PD 6-12	AEF	Application for Disability Income Insurance - Policy Details	Initial:	50.000	UN 2555 PD 6-12.pdf
6	Approved-Closed 08/03/2012	UN 2555 FI 6-12	AEF	Application for Disability Income Insurance - Policy & Financial Information	Initial:	50.000	UN 2555 FI 6-12.pdf
7	Approved-Closed 08/03/2012	DILQHQ 6-12	AEF	Application for Disability Income Insurance - Lifestyle & Health Questionnaire	Initial:	55.000	DILQHQ 6-12.pdf
8	Approved-Closed 08/03/2012	DIAG 6-12	AEF	Application for Disability Income Insurance - Agreement	Initial:	62.000	DIAG 6-12.pdf
9	Approved-Closed 08/03/2012	UN 1636 6-12	AEF	Application for Reinstatement/Policy Change - Disability Income Insurance	Initial:	51.000	UN 1636 6-12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form

State: Arkansas **Filing Company:** Ameritas Life Insurance Corp.
TOI/Sub-TOI: H11I Individual Health - Disability Income/H11I.004 Other
Product Name: 4504LS - Disability Income Product
Project Name/Number: 4504LS - Disability Income Product/4504LS et al.

CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

AMERITAS LIFE INSURANCE CORP.
5900 O Street
Lincoln, NE 68510

Client Service Office
[800-319-6901]
Fax: [513-595-2218]
[PO Box 40888
Cincinnati, OH 45240]

Insured: [John Doe]
Policy Number: [G1234567LA]

We will pay the benefits according to the terms of this policy.

LOOK AT THE APPLICATION FORMS. This policy is issued based on payment of the initial premium and the answers in the application (see copy attached). If all answers are not true and complete, this policy may be affected.

GUARANTEED RENEWABLE TO AGE 65

PLEASE READ THIS POLICY CAREFULLY. This policy is a legal contract between the *owner* and Ameritas Life Insurance Corp.

RIGHT TO EXAMINE. It is important to *us* that *you* are satisfied with this policy. *You* have 20 days to review this policy after *you* receive it. If this policy is a replacement for an existing policy *you* have 30 days to review this policy after *you* receive it. If *you* are not satisfied, *you* may send it back to *us* or give it to *our* agent. In such case, this policy will be void from the beginning and any premiums paid will be refunded.

AMERITAS LIFE INSURANCE CORP.

[SPECIMEN SPECIMEN]

[President Secretary]

Disability Income Policy
Nonparticipating

TABLE OF CONTENTS

POLICY SCHEDULE

Policy Number:	[G1234567LA]
Insured:	[John Doe]
Issue Age and Gender:	[35], [Male]
Occupational Class:	[2L]
Risk Class:	[Nontobacco]
Owner:	[John Doe]
Policy Date:	[July 1, 2012]
Issue Date:	[July 1, 2012]
Expiry Date:	[July 1, 2042]

POLICY SCHEDULE

Policy Information

Total Disability Benefit

Option A:	
Lump Sum Benefit	$[48,000]
Option B:	
Monthly Benefit	$[8,000]
Benefit Period	6 Months

Premium Information

[**Annual**] Premium	$[326.40]

Premium includes a $[24] policy fee.

Modal Premium Options

Mode	Premium
Annual	$[326.40]
Monthly	$[27.20]

PART I: DEFINITIONS

(Defined terms appear in italics throughout this policy.)

AGE. Means *your age* on *your* last birthday. The term "*age*" followed by a number, such as *age* 65, refers to the policy anniversary on or after *your* 65th birthday.

BENEFIT PERIOD. Means the period of time monthly benefits are paid. This period is shown on the *schedule*.

HOSPITAL. Means an institution licensed by law as a facility which:

(1) is primarily engaged in providing in-patient medical care for diagnosis and treatment of *injuries* or *sickness*, and charges a fee for such care; and
(2) is staffed by *physicians* on the premises; and
(3) provides services by registered graduate nurses 24 hours a day.

In no event will this include any institution which is:

(1) run mainly as a rest, nursing or convalescent home; or
(2) primarily operating for the care of the elderly; or
(3) is engaged in the education of its patients.

IN FORCE. Means premiums have been paid when due and *you* remain insured under the terms of this policy.

INJURY. Means any accidental bodily harm caused by a singular and distinct event occurring while this policy is *in force* and that is not contributed to by *sickness*.

ISSUE DATE. Means the date on which coverage begins. This date is shown on the *schedule*.

LAPSE. Means a premium is in default and *you* are no longer insured under this policy.

MENTAL/NERVOUS DISORDER. Means any disorder (except dementia resulting from stroke, trauma, infections or degenerative diseases, such as Alzheimer's disease) classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a period of disability. Such disorders include, but are not limited to, psychotic, emotional, or behavioral disorders, or disorders relatable to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then in use by the American Psychiatric Association as of the start of a period of disability.

OWNER. Means *you*, the insured, unless *our* records show otherwise. The rights of the *owner* are described in Part VI of this policy.

PHYSICIAN. Means a person (other than *you*, *your* spouse or domestic partner, a member of *your* family, a business or professional partner or any person with whom *you* share a financial or business interest) licensed by law in the state in which he or she practices and who is practicing within the scope of such license to treat *injury* or *sickness*. If a disability is due to a *mental/nervous disorder*, the *physician* must be a board-certified psychiatrist or a licensed doctoral-level psychologist.

POLICY DATE. Means the date from which policy anniversaries, policy years and premium due dates are determined. This date is shown on the *schedule*.

PROOF. Means records and statements, including but not limited to tax records, medical records, employment records, and financial records.

SCHEDULE. Means the policy *schedule* or revised policy *schedule* most recently sent to *you* by *us* that includes a summary of *your* benefits and premiums.

SICKNESS. Means any illness or disease first manifested while this policy is *in force*, including complications due to pregnancy or childbirth.

TOTAL DISABILITY BENEFIT. Means either the lump sum benefit or monthly benefit shown on the *schedule*.

TOTAL DISABILITY OR TOTALLY DISABLED. Means that, solely due to *sickness* or *injury*, *you* are not able to perform the material and substantial duties of any occupation for which *you* are reasonably suited based on *your* education, training, and experience.

WE, OUR, US. Means Ameritas Life Insurance Corp.

YOU, YOUR. Means the person insured under this policy as shown on the *schedule*.

PART II: BENEFIT PROVISIONS

BENEFIT FOR TOTAL DISABILITY. This policy pays for *total disability* only. *We* will pay the *total disability benefit*, if *you* suffer a *total disability* that begins while this policy is *in force*, and:

(1) is expected to last a minimum of 365 days; or
(2) results in death more than 30 days after and within 365 days of the onset of *total disability*.

No benefits are payable under this policy if *you* die within the first 30 days following the onset of a *total disability*.

Once benefits become payable under this policy in accordance with the Time of Payment of Claims provision in Part V of this policy, the *owner* may elect to receive payment monthly for the length of the *benefit period* or as a lump sum. These options are shown on the *schedule*. In no event will total benefits paid under this policy exceed the amount shown on the *schedule* for the lump sum benefit.

PHYSICIAN CARE REQUIREMENT. In order to be eligible for benefits under this policy, *you* must be under the regular care and treatment of a *physician* appropriate for the condition causing *total disability*.

CONCURRENT DISABILITIES. During a period of *total disability*, if a new disability occurs from a separate and distinct cause, it will not be considered the same disability. In no event will *we* pay for more than one *total disability* under this policy.

PART III: EXCEPTIONS/LIMITATIONS

WAR. Benefits are not payable for *sickness*, *injury* or disability caused or contributed to by war, declared or undeclared, or any act or incident of war, or as a result of military service when scheduled active duty is more than three months.

SELF-INFLICTED INJURY. Benefits are not payable for *sickness*, *injury* or disability resulting from an intentionally self-inflicted *injury*.

CRIMINAL ACTIVITY. Benefits are not payable during any period *you* are incarcerated; or for any *sickness*, *injury* or disability to which a contributing cause was *your* commission of, or attempt to commit, a felony; or for participation in a riot or insurrection; or while engaging in an illegal occupation.

TERMINATION OF LICENSE. Except as a direct result of a *sickness* or *injury*, benefits are not payable if *you* are prevented from engaging in an occupation as the result of suspension, revocation, or surrender of a professional or occupational license or certification.

MENTAL/NERVOUS DISORDERS, ALCOHOLISM, AND/OR DRUG ABUSE. If *you* suffer a compensable *total disability* that is caused by or contributed to by a *mental/nervous disorder*, alcoholism and/or drug abuse, the benefit payable will be limited to one-half of the *total disability benefit.* However, if *you* are expected to be confined to a *hospital* for at least 365 days due to that condition, *you* will receive the *total disability benefit*.

PRE-EXISTING CONDITIONS. *We* will not pay benefits for any disability that:

(1) begins in the first 12 months following the policy *issue date*; and
(2) is caused by or contributed to by a pre-existing condition.

A disability caused by or contributed to by a pre-existing condition may be covered only if it begins after 12 months from the policy *issue date* and has not been specifically excluded by name or specific description.

A pre-existing condition means any physical or mental condition for which during the 6-month period preceding the policy *issue date*:

(1) *you* have sought medical treatment; or
(2) symptoms existed that would have caused a reasonably prudent person to seek medical treatment.

Medical treatment includes medical advice or treatment, diagnostic procedures, or prescribed drugs or medication.

PART IV: PREMIUM AND RENEWAL PROVISIONS

PAYMENT OF PREMIUMS. The first premium is due on the *policy date*. Subsequent premiums are payable on or before the date they are due. Premiums must be paid to *us* at *our* client service office, P.O. Box 40888, Cincinnati, Ohio 45240. All premiums are payable in United States currency.

Your premium mode is shown on the *schedule*. *You* may request a change in the premium mode, subject to *our* approval.

If *we* accept a premium while this policy is *in force*, this policy will continue *in force* until the end of the period for which the premium was paid.

We will refund the unused portion of *your* premium in the event of *your* death.

GRACE PERIOD. A 31-day grace period is allowed for payment of premiums not paid on or before due dates. Coverage will continue *in force* during the grace period.

REINSTATEMENT. Within 90 days after this policy *lapses*, *we* will consider reinstatement of this policy upon payment of all past due premiums. *We* may require an application for reinstatement and evidence of insurability.

If *we* accept the past due premium with no further requirements, *we* will reinstate this policy effective the date the past due premium was received. If *we* require an application for reinstatement, this policy will be reinstated effective:

(1) when *we* approve *your* application; or
(2) 45 days after the date of the application unless *we* have refunded *your* premium and notified *you* in writing of *our* denial.

Following reinstatement, *your* policy will cover only:

(1) an *injury* that occurs after the date of reinstatement; or
(2) a *sickness* beginning more than 10 days after the date of reinstatement.

All other rights of this policy will remain the same except for changes made to this policy as a result of reinstatement.

GUARANTEED RENEWABLE TO AGE 65. *You* have the right to continue this policy to *age* 65 by paying the premium as due, subject to the Termination and Incontestability provisions in Part VI of this policy. While this policy is *in force*, *we* shall not:

(1) cancel this policy except for nonpayment of premium; nor
(2) add any restrictions.

PREMIUM RATES SUBJECT TO CHANGE. *We* reserve the right to change the premium rates. A change will apply to all policies of this form and class in the same state as the insured. Such change shall apply on the next policy anniversary after the change is made. The new premium will be based on the *age*, gender and occupation of the insured on the *issue date*.

SUSPENSION DURING SERVICE IN THE ARMED FORCES. If *you* are on active duty in any armed forces for more than 30 days, *you* have the option to suspend this policy. During such suspension:

(1) the provisions of this policy will not be in effect; and
(2) the contestable period in Part VI of this policy shall be tolled; and
(3) premium payments shall not be required.

You must request this suspension in writing. *We* will refund the part of any premium paid beyond *your* active duty date. If *your* active service ends before *you* reach *age* 65, *you* may reinstate this policy within 90 days after *your* active service ends. *We* must receive *your* request in writing along with *your* deactivation notice and payment of the premium due for coverage until the next premium due date. *We* will reinstate this policy effective the date premium is received. This policy will not cover disabilities from *injuries* which occurred, or *sickness* first manifested, while this policy was suspended. Otherwise, *you* and *we* shall have the same rights under this policy as each had before it was suspended.

PART V: CLAIM PROVISIONS

NOTICE OF CLAIM. A claim must be sent to *us* in writing within 30 days after the date of loss, or as soon as reasonably possible, thereafter. The notice of claim should be submitted to *us* at *our* client service office, P.O. Box 40888, Cincinnati, Ohio 45240, and must include *your* name and policy number.

CLAIM FORMS. When *we* receive *your* notice of claim, *we* will send *you* forms for filing *your proof* of loss. If *we* do not send these forms to *you* within 15 days after receipt of *your* notice of claim, *you* may meet the *proof* of loss by giving *us* a written statement describing the nature and extent of *your* loss. *You* should send it to *us* within the time limit stated below.

PROOF OF LOSS. It is *your* responsibility, at *your* expense, to submit to *us* written *proof* of loss within 90 days after the date of loss. If *you* are not able to send it within that time, it may be sent as soon as reasonably possible thereafter without affecting *your* claim. The additional time allowed cannot exceed one year unless *you* are legally incapacitated. *We* may request any additional *proof* of loss as necessary to evaluate *your* claim.

TIME OF LOSS. A loss must occur while this policy is *in force*.

TIME OF PAYMENT OF CLAIMS. Subject to receipt of satisfactory written *proof* of loss, *we* will immediately pay the *total disability benefit* due, upon *our* determination that benefits are payable under this policy.

REFUND OF PREMIUM. *You* must continue to pay premium until *your* claim has been approved by *us*. If *your* claim is approved by *us*, *we* will refund any premium *you* have paid back to the date *you* became *totally disabled*.

PAYMENT OF CLAIMS. *You* must satisfy all terms and conditions of this policy in order for benefits to become payable. All benefits are payable to the *owner*, unless assigned to another person.

If the person who is to receive payments is dead or incompetent, *we* will make the payments to the legal representative for the property of that person. If no legal representative exists, *we* may make payment to any relative of that person *we* consider to be justly entitled to payment. If *we* do this, *we* will be discharged to the extent of such payment made in good faith. The amount *we* pay will not exceed $5,000 or, if greater, the limit allowed by state law for payments of this kind.

MEDICAL EXAMINATION. *We* have the right as necessary, at *our* expense, to obtain other medical opinions from, or have *you* examined by, *physicians* of *our* choice. *We* also have the right, at *our* expense, to obtain from a specialist of *our* choice; vocational evaluations, functional capacity evaluations, and any other evaluations and examinations necessary to assess *your* claim.

LEGAL ACTIONS. No legal action may be brought to recover on this policy within 60 days after written *proof* of loss has been given as required by this policy. No such action may be brought after three years from the time written *proof* of loss is required to be given. All actions must be brought in either a state or federal court within the United States.

FRAUD. In the event this policy, benefit, or reinstatement of this policy is procured by fraud or a claim is made with intent to deceive, this policy will be void. This provision shall control over all other policy provisions.

PART VI: GENERAL PROVISIONS

INCONTESTABILITY. After three years from the *issue date* of this policy or the effective date of any change to this policy or reinstatement, only fraudulent misstatements in the application may be used to void this policy or any change to this policy or deny a claim for loss incurred or disability that starts after the three-year period. However, for disabilities that start during this three-year period, *we* may void *your* policy if *you* made material misrepresentations in *your* application.

Applications include the application for this policy and any amendments or supplemental applications including those used for reinstatement or policy changes.

POLICY OWNERSHIP. *You* are the *owner* of this policy unless *our* records show otherwise. The *owner* has the right to:

(1) receive any benefits due under this policy; and
(2) assign this policy; and
(3) exercise other rights that this policy provides, or that *we* permit.

CHANGE OF BENEFICIARY. The *owner* can change the beneficiary at any time by giving *us* written notice. The beneficiary's consent is not required for this or any other change in this policy, unless the designation of the beneficiary is irrevocable.

MISSTATEMENT OF AGE AND GENDER. If *your age* or gender has been misstated, *your* benefits will be adjusted to reflect the amount *your* premium would have purchased at *your* correct *age* and gender. If, however, no coverage would have been issued at the correct *age*, *you* will not be covered and *we* will refund all premiums paid.

ENTIRE CONTRACT. The entire contract consists of:

(1) this policy; and
(2) any endorsements; and
(3) the attached copy of the application, and any amendments or supplemental applications; and
(4) the applicable *schedule(s).*

No change in this policy will be effective until approved by one of *our* authorized officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

NONPARTICIPATING POLICY. This policy is nonparticipating. No dividends will be paid under this policy.

HEADINGS. The paragraph headings in this policy are included for convenience only and do not modify or control the scope of any of the provisions of this policy.

CONFORMITY WITH STATE STATUTES. If any provisions of this policy are in conflict with the laws of the state where *you* reside on the *issue date* of this policy, those provisions are amended to conform to the minimum requirements of those laws.

DUTY TO COOPERATE. *You* have the duty to cooperate with *us* concerning all matters relating to this policy and any claims thereunder. This cooperation includes, but is not limited to:

(1) submitting all required forms and other documentation according to this policy's provisions; and
(2) mitigating all covered expenses; and
(3) securing appropriate medical treatment for the condition(s) upon which *your* claim for benefit under this policy is based. This includes such corrective/remedial surgery or generally accepted medical procedures which to a *physician* appropriate for such condition(s) would appear medically reasonable.

TERMINATION. This policy terminates on the earlier of the following:

(1) the expiry date shown on the *schedule*;
(2) the end of the period for which premium has been paid, if premium is not paid by the end of the grace period; or
(3) the date *we* receive the *owner's* written request to terminate this policy; or
(4) the date of *your* death; or
(5) once the *total disability benefit* is paid under this policy.

Disability Income Policy
Nonparticipating

Ameritas Life Insurance Corp.

OUTLINE OF COVERAGE

for

Disability Income Protection Coverage

(This form for use with Policy Form 4504LS or appropriate state variation thereof)

(1) READ *YOUR* POLICY CAREFULLY. This outline of coverage gives a very brief description of some of the important features of *your* policy. This is not the insurance contract. Only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both *you* and *your* insurance company. It is, therefore, important that *you* READ *YOUR* POLICY CAREFULLY.

(2) DISABILITY INCOME PROTECTION COVERAGE. This policy provides a benefit for a *total disability* that results from *injury* or *sickness*. Some *injuries* or *sicknesses* may not be covered. All covered disabilities must begin while this policy is *in force*. Payments will be made to the policy *owner*. This policy terminates once the *total disability benefit* is paid under the policy. The major benefits and limitations of *your* policy are listed below. This policy will not pay for *hospital*, medical, surgical, or other health care expenses.

(3) RENEWABILITY OF *YOUR* POLICY. *We* cannot cancel *your* policy before *age* 65, except for non payment of premium. *We* reserve the right to change premium rates.

(4) BASE POLICY BENEFITS.

Total Disability Benefit: $[48,000]

This policy pays for *total disability* only. *We* will pay the *total disability benefit*, if *you* suffer a *total disability* that begins while this policy is *in force* and is expected to last a minimum of 365 days or results in death more than 30 days after and within 365 days of the onset of *total disability*.

TOTAL DISABILITY. *Total disability* or *totally disabled* means that, solely due to *sickness* or *injury*, *you* are not able to perform the material and substantial *duties* of any occupation for which *you* are reasonably suited based on *your* education, training, and experience.

PHYSICIAN CARE REQUIREMENT. In order to be eligible for the *total disability benefit* under this policy, *you* must be under the regular care and treatment of a *physician* appropriate for the condition causing *total disability*.

(5) EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF *YOUR* POLICY.

This policy does not cover *sickness*, *injury*, or disability caused:

(1) by war, declared or undeclared, or any act or incident of war; or
(2) by an intentionally self-inflicted *injury*; or
(3) by *your* incarceration for any reason; or
(4) by or contributed to by *your* commission of a felony, or participation in a riot, insurrection or illegal occupation; or
(5) as a result of the suspension, revocation or surrender of *your* professional or occupational license or certification.

Pre-existing Conditions:

We will not pay benefits for any disability that:

(1) begins in the first 12 months following the policy *issue date*; and
(2) is caused by or contributed to by a pre-existing condition.

A disability caused by or contributed to by a pre-existing condition may be covered only if it begins after 12 months from the policy *issue date* and has not been specifically excluded by name or specific description.

A pre-existing condition means any physical or mental condition for which during the 6-month period preceding the policy *issue date*:

(1) *you* have sought medical treatment; or
(2) symptoms existed that would have caused a reasonably prudent person to seek medical treatment.

This policy has limited benefits if loss is caused by mental or nervous disorders, alcoholism or drug abuse.

(6) SCHEDULE OF PREMIUMS.

Total [**Annual**] Premium $[326.40]

Premium includes a $[24] policy fee.

GRACE PERIOD. A 31-day grace period is allowed for payment of premiums not paid on or before due dates. Coverage will continue *in force* during the grace period. If a premium is not paid by the end of the grace period, the policy will *lapse* as of the end of the period for which premium was paid.

Producer's Signature: _____ Date: _____

Producer's Address: _____ Phone:_____

Ameritas Life Insurance Corp.

EXCLUSIONS/LIMITATIONS ENDORSEMENT

This endorsement is attached to and made a part of Policy _____ issued to _____ _____, the insured.

Anything in this policy to the contrary notwithstanding.

This endorsement is effective on the *issue date* of the policy to which it is attached.

AMERITAS LIFE INSURANCE CORP.

[SPECIMEN SPECIMEN]

[President Secretary]

Witness: _____ Insured: _____

Date: _____

AEXENM

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

Application for Disability Income Insurance

Personal Information

1. Proposed Insured

a) Name: _____ b) Gender: ☐ Male ☐ Female

c) Address: _____ d) Daytime Phone: _____

e) Social Security/Tax ID Number: _____ f) Driver's License Number: _____ State: _____

g) Date of Birth: _____ h) Place of Birth: _____

i) Are you a U.S. Citizen or Permanent Resident? ☐ Yes ☐ No If "No," Citizenship: _____ Visa Type: _____

2. Owner (Complete only if Owner is other than Proposed Insured)

a) ☐ Individual ☐ Trust *(provide copy)* ☐ Partnership ☐ Corporation: County of Incorporation: _____

b) Name: _____

c) Address: _____ d) Daytime Phone: _____

e) Social Security/Tax ID Number: _____ f) Driver's License Number: _____ State: _____

g) Date of Birth: _____ h) Relationship to Proposed Insured: _____

i) Are you a U.S. Citizen or Permanent Resident? ☐ Yes ☐ No If "No," Citizenship: _____ Visa Type: _____

j) Trustee(s) Name(s): _____ k) Date of Trust: _____

3. Beneficiary Information (in the event benefits are payable after death)

a) Primary Beneficiary: _____ Date of Birth or Trust: _____

Address: _____

Relationship to Proposed Insured: _____ Social Security/Tax ID Number: _____

b) Contingent Beneficiary: _____ Date of Birth or Trust: _____

Address: _____

Relationship to Proposed Insured: _____ Social Security/Tax ID Number: _____

4. Occupation

a) Primary Employer: _____

b) Address: _____

c) Current occupation(s): _____ d) Years: _____ e) Business Phone: _____

f) Physical/Manual duties: _____% g) Description of occupational duties: _____

_____

h) Do you work at least 30 hours per week in your primary occupation? ☐ Yes ☐ No

i) Within the past five years, has your professional license been suspended or revoked; or is your license under review; or have you been disbarred? ☐ Yes ☐ No

If "Yes," give details: _____

_____

j) If you work for another employer other than noted above, provide details *(name of employer, occupation, duties, years)*:

_____

_____

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

Application for Disability Income Insurance

Policy Details

1. Policy Details - DInamic Foundation

a) Contract Type:
☐ Noncancelable and Guaranteed Renewable (4501NC) ☐ Guaranteed Renewable (4502GR)

b) Definition of Disability:
☐ Own Occ for benefit period (OO) ☐ Own Occ and Not Working for benefit period (NW)
☐ 60 month Own Occ and Not Working thereafter (ON)

c) Base Monthly Benefit: $_____

d) Elimination Period *(days)*: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730

e) Benefit Period: ☐ 1 Year ☐ 2 Years ☐ 5 Years ☐ 10 Years ☐ To Age 65 ☐ To Age 67 ☐ To Age 70

f) Riders:
☐ Enhanced Residual Disability Rider ☐ Basic Residual Disability Rider
☐ Cost of Living Adjustment Rider – 6% Compound ☐ Cost of Living Adjustment Rider – 3% Simple
☐ Social Insurance Substitute Rider: $_____ Elimination Period *(days)*:_____
☐ Catastrophic Disability Rider: $_____ Elimination Period *(days)*:_____ Benefit Period *(years)*:_____
☐ Future Increase Option Rider: $_____ ☐ Automatic Increase Rider
☐ Other: _____

g) Do you understand and agree that under the terms of the Individual Disability Income policy applied for, no monthly benefit is payable during the elimination period of any disability? ☐ Yes ☐ No

2. Special Premium Information

a) Association Discount: ☐ Yes ☐ No If "Yes," give Association IPN: _____

b) Percentage of premium to be paid by your employer _____%. Will it be included in your taxable income? ☐ Yes ☐ No

3. Business Information

a) How many total employees are there in the business where you work? _____

b) How long have you been employed at the business where you work? _____

c) Do you have any ownership in the business where you work? ☐ Yes ☐ No If "Yes," what percent do you own? _____% and what type of business is it? ☐ C-Corp ☐ S-Corp ☐ Partnership ☐ Sole Proprietorship

4. Detailed Financial Information

a) Annual Earned Income for Federal income tax purposes *(complete each applicable section):*

	Last Tax Year	Two Tax Years Ago
Salary/W-2 wages:	$_____	$_____
Business Income:	$_____	$_____

b) Annual Unearned Income for Federal income tax purposes, if greater than $20,000 *(rental income, interest, dividends, etc.)*: $_____

c) Net Worth *(if net worth exceeds $4,000,000)*: $_____

5. Previous Insurance Details

a) Do you have any group or individual disability insurance in force, or for which you will become eligible in the next year, or applications currently pending? ☐ Yes ☐ No

b) If "Yes," list coverage details below: *(For type of coverage, indicate as: group, individual, association, overhead expense, key person, buy-out, etc.)*

	Policy 1	Policy 2
Company:	_____	_____
Type of Coverage:	_____	_____
Total Monthly Benefit:	_____	_____
Issue Date:	_____	_____
Social Security Benefit:	_____	_____
Catastrophic Benefit:	_____	_____
Employer Paid:	_____	_____

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

Application for Disability Income Insurance

Financial and Policy Information

1. Basic Financial Information

a) Annual Earned Income for Federal income tax purposes *(complete each applicable section):*

Annual Salary, Bonus, Variable Compensation *(W-2 wages)*:	$
Annual pension or profit sharing contribution from employer:	$
If business owner, your share of annual net business income *(after expenses)*:	$

b) Within the past two years, have you filed for personal or business bankruptcy; or had judgments against you? . . . . . ☐ Yes ☐ No

If "Yes," give details to include dates, amounts, location, and status: _____

_____

2. Existing Insurance

a) Do you have any other disability insurance that pays a lump sum benefit in force or pending with this company or any other insurance company? . . . . . ☐ Yes ☐ No

If "Yes," name of company and benefit amount: _____

b) Will any disability insurance with this company or any other insurance company be replaced, reduced or changed if the insurance now applied for is issued? . . . . . ☐ Yes ☐ No

If "Yes," give details. Company: _____

Policy Number: _____ Amount to be replaced: $_____ Other changes: _____

c) Insurance Producer's Replacement Statement: To the best of your knowledge, does the policy applied for involve replacement, in whole or in part, of any existing disability income insurance, or any other accident and sickness insurance? . . . . . ☐ Yes ☐ No

If "Yes," give details. Company: _____

Policy Number: _____ Amount to be replaced: $_____

3. Premium

a) Premium Payor: ☐ Insured ☐ Employer ☐ Other: _____

b) Address for Premium Notices: _____

c) Premium Frequency: ☐ Annual ☐ Monthly Electronic Funds Transfer *(complete EFT form)* ☐ Other: _____

Salary Allotment/List Bill (#: _____)

d) Has any premium been given in connection with this application? ☐ Yes ☐ No
If "Yes," state amount paid for which Conditional Receipt has been given, the terms of which are hereby agreed to: $ _____

4. Policy Details - DInamic Fundamental

a) Benefit Amount *(lump sum payment)*: $_____

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

Application for Disability Income Insurance

Lifestyle and Health Questionnaire

Lifestyle Questions *(provide details for "Yes" answers below)*

1) Within the past 12 months, have you used tobacco or nicotine products in any form *(including nicotine patches/gum)*?	☐ Yes	☐ No
2) Within the past five years, have you had a driver's license revoked or suspended?	☐ Yes	☐ No
3) Have you been charged with, or convicted of, or currently awaiting trial for a felony violation of any criminal law?	☐ Yes	☐ No
4) Within the next two years, do you have any intention of residing outside of the U.S. or traveling outside of the U.S. or Canada?	☐ Yes	☐ No
5) Within the past two years, have you engaged in, or in the next twelve months do you plan to engage in, any hazardous activities *(such as scuba diving, motorized racing, skydiving, hang-gliding, mountain climbing, aviation)*?	☐ Yes	☐ No

Details for all "Yes" answers to Lifestyle Questions *(include question numbers, dates, etc.)*. Attach additional sheet, if needed.

Health Questions *(provide details for "Yes" answers below)*

1) Have you ever received or applied for disability insurance benefits due to sickness or injury?	☐ Yes	☐ No
2) Have you ever applied for insurance or reinstatement which has been declined, postponed, rated, modified, or had any such insurance canceled or a renewal premium refused?	☐ Yes	☐ No
3) Within the past six months, have you missed work due to, or been treated for, sickness or injury?	☐ Yes	☐ No
4) Have you been diagnosed with, medically treated for, or had any known indication of:	☐ Yes	☐ No
a) heart attack, angina, coronary artery disease, stroke, mini-stroke, high blood pressure *(include last reading in details)* or any other type of heart or circulatory system disease?	☐ Yes	☐ No
b) any form of cancer *(including leukemia, lymphoma, or cancer of the bone marrow)*?	☐ Yes	☐ No
c) any chronic or progressive disease or disorder of the: kidneys, liver, lung or respiratory system, pancreas, muscles or connective tissue, joints, eyes, ears, bone marrow, digestive system, brain, nervous system or immune system; or have you been diagnosed with sleep apnea or diabetes *(non pregnancy related)*?	☐ Yes	☐ No
d) seizures, anxiety, depression, Epstein-Barr virus, chronic fatigue, or fibromyalgia?	☐ Yes	☐ No
e) spine, neck or back disease or disorder?	☐ Yes	☐ No
5) Have you been diagnosed by a licensed medical professional or tested positive for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	☐ Yes	☐ No
6) Are you taking any prescription medications on a regular basis?	☐ Yes	☐ No
7) Within the past ten years, have you used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics, or any other drug except as legally prescribed by a physician, or sought or received treatment for the use of alcohol?	☐ Yes	☐ No
8) Within the past five years, other than noted above, have you been a patient in a hospital or other medical facility?	☐ Yes	☐ No
9) Your Height: _____ Your Weight: _____ Have you lost or gained 20 or more pounds in the past 12 months?	☐ Yes	☐ No

Provide details below for all "Yes" answers to Health Questions. Attach additional sheet, if needed.

Question Number	Description of Disorder, Disease or Injury	Month/Year of Diagnosis	Duration/Number of Episodes	Treatment, Degree of Recovery, and Remaining Problems or Symptoms	Name of Attending Physician and Date of Last Visit

Ameritas Life Insurance Corp.

P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2352
(Client Service Office)

Application for Disability Income Insurance

Agreement

Agreement

The undersigned represent that their statements in this application and Part II, if such Part II is required by Ameritas Life Insurance Corp. (the Company), are true and complete to the best of their knowledge and belief. It is agreed that:

(a) the only statements to be considered as the basis of the policy are those contained in the application or in any amendment to the application;

(b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT;

(c) if there is no prepayment made with this application, the policy will not take effect until:

(1) the first premium is paid during the lifetime of the proposed insured and while his/her health and the facts and other conditions affecting his/her insurability remain as described in this application and Part II, if required; and

(2) the policy is delivered to the Owner;

(d) no one except the President, a Vice President, the Secretary, or an Assistant Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements; and

(e) this application was signed and dated in the state indicated.

Fraud Notice

Any person who knowingly or with intent to defraud; submits an application or files a claim containing false, incomplete or misleading information; is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name

X _____
Signature of Proposed Insured

_____
Print or Type Owner if not Proposed Insured

X _____
Signature of Owner if not Proposed Insured

_____ _____
Print or Type Insurance Producer Name Producer No./Sit. Code

X _____ _____
Signature of Licensed Soliciting Producer Producer State Lic. No.

_____ _____
Print or Type Insurance Producer Name Producer No./Sit. Code

X _____ _____
Signature of Licensed Soliciting Producer Producer State Lic. No.

_____ _____
Agency Name Agency No.

Taxpayer Identification Number (TIN)

Social Security Number	Employer Identification Number

Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct TIN (or I am waiting for a number to be issued to me); and

(2) I am not subject to backup withholding either because: (a) I am exempt from backup withholding; (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding.

(3) I am a U.S. Citizen or other U.S. Person (including a U.S. resident alien).

Cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

X _____
Signature of Owner, Trustee/Employer Date

Ameritas Life Insurance Corp.
P.O. Box 40888, Cincinnati, OH 45240
800-319-6901, Fax 513-595-2218
(Client Service Office)

Application for Disability Income Insurance Reinstatement/Policy Change

The undersigned hereby requests and directs the Ameritas Life Insurance Corp. to reinstate/change the policy numbered _____ _____ on the insured _____ as follows:

1. ☐ **Reinstate the policy** ***(complete questions 3 & 4 below and Lifestyle/Health Questionnaire, DILQHQ)***

2. ☐ **Change the policy according to the following specifics:**

☐ Decrease Total Disability Benefit to: $_____

☐ Change Premium Mode to: ☐ Annual ☐ Monthly Electronic Funds Transfer *(complete EFT form)*

☐ Change Tobacco Status to Non-Tobacco *(complete Lifestyle/Health Questionnaire, DILQHQ)*

☐ Reconsider Policy Exclusion *(complete question 3 below and Lifestyle/Health Questionnaire, DILQHQ)*

☐ Change Occupation Class to: _____ *(complete questions 3 & 4 below and Lifestyle/Health Questionnaire, DILQHQ)*

☐ Other: _____

3. Occupation

a) Primary Employer: _____

b) Address: _____

c) Current occupation(s): _____ d) Years: _____ e) Physical/Manual duties: _____ %

f) Description of occupational duties: _____

g) Do you work at least 30 hours per week in your primary occupation? ☐ Yes ☐ No

h) Within the past five years, has your professional license been suspended or revoked; or is your license under review; or have you been disbarred? ☐ Yes ☐ No If "Yes," give details: _____

_____

i) If you work for another employer other than noted above, provide details *(name of employer, occupation, duties, years)*: _____

_____

4. Financial Information

a) Annual Earned Income for Federal income tax purposes *(complete each applicable section)*:

Annual Salary, Bonus, Variable Compensation *(W-2 wages)*:	$
Annual pension or profit sharing contribution from employer:	$
If business owner, your share of annual net business income *(after expenses)*:	$

b) Within the past two years, have you filed for personal or business bankruptcy; or had judgements against you? ☐ Yes ☐ No

If "Yes," give details to include dates, amounts, location, and status: _____

_____

c) Do you have any other disability insurance that pays a lump sum benefit in force or pending? ☐ Yes ☐ No

If "Yes," provide name of company and benefit amount: _____

_____

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***		***Company Tracking #:***	*4504LS ET AL.*

State:	*Arkansas*	***Filing Company:***	*Ameritas Life Insurance Corp.*
TOI/Sub-TOI:	*H11I Individual Health - Disability Income/H11I.004 Other*		
Product Name:	*4504LS - Disability Income Product*		
Project Name/Number:	*4504LS - Disability Income Product/4504LS et al.*		

Rate Information

Rate data applies to filing.

Filing Method:	Electronic
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	n/a

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Ameritas Life Insurance Corp.	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***		***Company Tracking #:***	*4504LS ET AL.*

State:	*Arkansas*	***Filing Company:***	*Ameritas Life Insurance Corp.*
TOI/Sub-TOI:	*H11I Individual Health - Disability Income/H11I.004 Other*		
Product Name:	*4504LS - Disability Income Product*		
Project Name/Number:	*4504LS - Disability Income Product/4504LS et al.*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action*	Rate Action Information	Attachments
1	Approved-Closed 08/03/2012	Annual Rates per $1,000	4504LS AR	New		Annual Rates per $1,000.pdf

Ameritas Life Insurance Corp.
Form 4504LS
Guaranteed Renewable Disability Income
Annual Premiums per $1,000

	Non-Tobacco				
	1L			2L	
Age	Male	Female		Male	Female
18	2.50	3.40		3.30	4.00
19	2.50	3.40		3.30	4.00
20	2.50	3.40		3.30	4.00
21	2.60	3.50		3.40	4.10
22	2.60	3.60		3.50	4.30
23	2.70	3.70		3.60	4.40
24	2.80	3.80		3.70	4.60
25	2.90	3.90		3.90	4.70
26	3.10	4.20		4.10	5.10
27	3.30	4.40		4.30	5.50
28	3.50	4.70		4.50	5.90
29	3.70	5.00		4.70	6.30
30	3.80	5.20		5.00	6.70
31	4.00	5.50		5.20	7.00
32	4.20	5.80		5.50	7.40
33	4.40	6.00		5.70	7.80
34	4.60	6.30		6.00	8.20
35	4.80	6.60		6.30	8.60
36	5.00	6.90		6.60	9.00
37	5.30	7.20		6.90	9.40
38	5.50	7.50		7.30	9.90
39	5.80	7.80		7.60	10.40
40	6.00	8.10		8.00	10.90
41	6.30	8.50		8.50	11.40
42	6.70	8.90		8.90	11.90
43	7.00	9.20		9.40	12.50
44	7.30	9.70		9.90	13.10
45	7.70	10.10		10.40	13.80
46	8.10	10.50		11.00	14.50
47	8.60	11.00		11.60	15.20
48	9.00	11.50		12.20	16.00
49	9.50	12.10		12.90	16.80
50	9.90	12.50		13.30	17.20
51	10.60	13.20		14.40	18.60
52	11.20	13.90		15.20	19.60
53	11.80	14.50		16.10	20.70
54	12.50	15.20		17.00	21.80
55	13.20	16.00		17.90	22.90
56	14.00	16.80		19.00	24.20
57	14.80	17.60		20.00	25.50
58	15.60	18.50		21.10	26.80
59	16.50	19.40		22.30	28.30
60	17.40	20.30		23.50	29.80
61	18.40	21.30		24.80	31.40
62	19.50	22.40		26.20	33.10
63	20.60	23.50		27.60	34.90
64	21.70	24.70		29.10	36.70

$24 annual policy fee
Add 20% for tobacco users

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***	***Company Tracking #:*** *4504LS ET AL.*

State:	*Arkansas*	***Filing Company:***	*Ameritas Life Insurance Corp.*
TOI/Sub-TOI:	*H11I Individual Health - Disability Income/H11I.004 Other*		
Product Name:	*4504LS - Disability Income Product*		
Project Name/Number:	*4504LS - Disability Income Product/4504LS et al.*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	08/03/2012
Comments:	We are attaching the appropriate Certifications, along with an informational copy of our Consumer Information Notice and our Guaranty Association Notice.		
Attachment(s):			
1683 AR.pdf 1684 AR.pdf AR reg 49.pdf AR reg 6.pdf AR reg 19.pdf Univ Readability Cert.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	08/03/2012
Comments:	The base application to be used with this product is attached under the Form Schedule Tab for review and approval.		

		Item Status:	**Status Date:**
Satisfied - Item:	Outline of Coverage	Approved-Closed	08/03/2012
Comments:	Please refer to the Form Schedule Tab.		

		Item Status:	**Status Date:**
Satisfied - Item:	Statements of Variability	Approved-Closed	08/03/2012
Comments:			
Attachment(s):			
Statement of Variability - Applications.pdf Statement of Variability for 4504LS.pdf Statement of Variability for 4504LS OC.pdf			

		Item Status:	**Status Date:**

SERFF Tracking #:	*AMFA-128526847*	***State Tracking #:***	***Company Tracking #:*** *4504LS ET AL.*

State:	*Arkansas*	***Filing Company:***	*Ameritas Life Insurance Corp.*
TOI/Sub-TOI:	*H11I Individual Health - Disability Income/H11I.004 Other*		
Product Name:	*4504LS - Disability Income Product*		
Project Name/Number:	*4504LS - Disability Income Product/4504LS et al.*		

Satisfied - Item:	Exhibits A and B	Approved-Closed	08/03/2012
Comments:			
Attachment(s):			
Exhibit A with OC.pdf Exhibit B - Brief Description.pdf			

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

* They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
* The insurer was not authorized to do business in this state;
* Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

* Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
* Any policy of reinsurance (unless an assumption certificate was issued);
* Interest rate yields that exceed an average rate;
* Dividends and voting rights and experience rating credits;
* Credits given in connection with the administration of a policy by a group contract holder;
* Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
* Unallocated annuity contracts (which give rights to group contract holders, not individuals);
* Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
* Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
* Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
* Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
* Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

IMPORTANT INFORMATION TO POLICYHOLDERS

For information concerning your policy, contact your agent or the company as follows:

Agent Name: Mr Lance B Kolbet Lutcf

Agent Address: Ste 255
275 S 5th Ave
Pocatello ID 83201

Agent Phone: (208) 234-1800

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, Nebraska 68501-1889
1-800-745-1112

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494
501-371-2640

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.

CERTIFICATION
Arkansas

We hereby certify that we have reviewed Arkansas Rule and Regulation 49 and that Ameritas Life Insurance Corp. is in compliance regarding Life and Health Insurance Guaranty Association Notices.

We also certify that we have reviewed ACA 23-79-138 regarding the use of Complaint Notices, and Regulation 6, and assure that Ameritas Life Insurance Corp. is in compliance.

Robert G. Lange
Vice President, General Counsel and Asst. Secretary

July 23, 2012
Date

Reg. Section 6 DI: Method of Disclosure of Required Information

All information required to be disclosed by this rule shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

ar3.doc

CERTIFICATION
Arkansas

We hereby certify that we have reviewed Regulation 6 and that Ameritas Life Insurance Corp. is in compliance.

Robert G. Lange
Vice President, General Counsel and Assistant Secretary

July 23, 2012
Date

Reg. Section 6 DI: Method of Disclosure of Required Information

All information required to be disclosed by this rule shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

Reg. Section 6 Life: Valuation

The minimum valuation standard for universal life insurance policies shall be the Commissioners Reserve Valuation Method

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CERTIFICATION
Arkansas

We hereby certify that we have reviewed Rule and Regulation 19 and that Ameritas Life Insurance Corp. meets the provisions of said Rule and Regulation, as well as all applicable requirements of your Department regarding Unfair Sex Discrimination in the Sale of Insurance.

Robert G. Lange
Vice President, General Counsel and Asst. Secretary

July 23, 2012
Date

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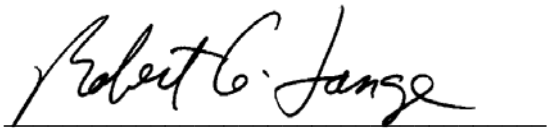
UNIVERSAL READABILITY CERTIFICATION

I, Robert G. Lange, an officer of Ameritas Life Insurance Corp., hereby certify that the following forms have the indicated readability scores as calculated by the Flesch Reading Ease Test, and that these forms meet the reading ease requirements of the laws and regulations of your state.

See attached Exhibit A.



Robert G. Lange
Vice President, General Counsel
& Assistant Secretary

July 31, 2012
Date

Ameritas Life Insurance Corp.

Statement of Variability

Applications

The following is bracketed on all application pages. These items have been bracketed in the event they change in the future.

1. General Company Information

(a) Client Service Office Address

(b) Client Service Office Phone Number, Fax Number

Statement of Variability for Policy 4504LS

POLICY COVER: The following information is bracketed on the policy cover.

1. (a) Client Service Office Phone Number
   (b) Client Service Office Fax Number
   (c) Client Service Office Address
   (d) Insured
   This information is personalized to the policy purchased. It is included as John Doe specimen information in the submitted policy.
   (e) Policy Number
   This information is personalized to the policy purchased. It is included as John Doe specimen information in the submitted policy.
   (f) Officer Signatures and Titles

SCHEDULE PAGES: The following are the various options for the bracketed items on the Schedule Page.

2. Policy Number, Insured, Issue Age, Owner, Policy Date, Issue Date: This information is personalized to the policy purchased and included as John Doe specimen information in the submitted policy.

3. Gender: Male and Female

4. Occupational Class: 1L and 2L

5. Risk Class: Nontobacco, Tobacco

6. Expiry Date: The policy anniversary following the insured's 65^{th} birthday.

7. Lump Sum Benefit: Policies are tailored to each insured. Minimum benefit is $25,000 and the maximum is $100,000.

8. Monthly Benefit: Policies are tailored to each insured. Minimum monthly benefit is $4,165 and the maximum is $16,670.

9. Premium Information: Premiums vary by insured and are a function of several factors such as occupation class, age, tobacco use, and benefit amount. Optional modes are annual, semi-annual, quarterly, and monthly. Policy fee options correspond to the premium mode and include $24, $12, $6 and $2, respectively.

Statement of Variability for Outline of Coverage
4505LS OC

1. Total Disability Benefit: Policies are tailored to each insured. Minimum benefit is $25,000 and the maximum is $100,000.

2. Premium Information: Premiums vary by insured and are a function of several factors such as occupation, age, tobacco use, and benefit amount. Optional modes are annual, semi-annual, quarterly, and monthly. Policy fee options correspond to the premium mode and include $24, $12, $6 and $2, respectively.

Exhibit A - With Outlines of Coverage
Forms Submitted for Approval

Form Number	Description	Flesch Score
4504LS	Guaranteed Renewable Policy	55
4504LS OC	Guaranteed Renewable Policy- Outline of Coverage	52
AEXENM	Exclusions / Limitations Endorsement	62
UN 2555 PI 6-12	Application for Disability Income Insurance - Personal Information	60
UN 2555 PD 6-12	Application for Disability Income Insurance - Policy Details	50
UN 2555 FI 6-12	Application for Disability Income Insurance - Financial & Policy Information	50
DILQHQ 6-12	Application for Disability Income Insurance - Lifestyle & Health Questionnaire	55
DIAG 6-12	Application for Disability Income Insurance - Agreement	62
UN 1636 6-12	Application for Reinstatement/Policy Change - Disability Income Insurance	51

- The following forms will be used together to create a base application for Disability Income policy 4504LS:

  UN 2555 PI 6-12
  UN 2555 FI 6-12
  DILQHQ 6-12
  DIAG 6-12

  These pages, along with UN 2555 PD 6-12, will also be used with Disability Income policies (4501NC and 4502GR) that were previously approved by your Department between 04/12/11 and 07/02/12

- The following forms will be used together to create an Application for Reinstatement/Policy Change for policy 4504LS:

  UN 1636 6-12
  DILQHQ 6-12
  DIAG 6-12

- AEXENM will also be used with our Disability Income policies (4501NC and 4502GR) that were previously approved by your Department between 04/12/11 and 07/02/12.

Exhibit B

Brief Description of Policy Forms and Applications

Policy Forms

Guaranteed Renewable Disability Income Policy (Form 4504LS): This is an individual disability income policy that pays a monthly benefit for six months (or an equivalent lump sum benefit, at the option of the insured) for a covered total disability which results from an accident or sickness. The premium paying and coverage periods will be through the policy anniversary following the insured's 65th birthday. Premiums for this form are subject to change.

Exclusion Endorsement (AEXENM): This form is used to exclude from coverage an injury or sickness which occurs as the result of the applicant's participation in a named event (such as participation in a hazardous sport or activity) that was disclosed during the underwriting process for new business. The exclusion is understood, agreed to, and signed by the insured and is made part of the policy.

Applications

UN 1636 6-12: This application is used to request reinstatement of lapsed coverage and/or request policy changes.

UN 2555 PI 6-12, UN 2555 FI 6-12, UN 2555 PD 6-12: These pages make up our base application for new business.

DILQHQ 6-12: This form asks about the applicant's lifestyle and medical history and is used in conjunction with the new business or the reinstatement/change application (UN 2555 PI 6-12, et al., and UN 1636 6-12)

DIAG 6-12: This agreement page is used in conjunction with the new business or the reinstatement/change application (UN 2555 PI 6-12, et al., and UN 1636 6-12).